ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

Name: Paul Berrini





ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD APPLICATION FOR EXEMPTION PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION | VED

This Section must be completed for all projects.	AUG 2 1 2017
Facility/Project Identification	HEALTH FACILITIES &
Facility Name: Holy Cross Hospital	SERVICES REVIEW BOAR
Street Address: 2701 West 68th Street	
City and Zip Code: Chicago, IL 60629	
	ealth Planning Area:A-03
Applicant(s) [Provide for each applicant (refer to Part 1130.220)]	
Exact Legal Name: Holy Cross Hospital	
Street Address:2701 West 68 th Street	
City and Zip Code: Chicago, IL 60629	
Name of Registered Agent: Karen Teitelbaum	
Registered Agent Street Address:1500 South California Avenue F104A	
Registered Agent City and Zip Code: Chicago, IL 60608	
Name of Chief Executive Officer: Karen Teitelbaum	
CEO Street Address: 1500 South California Avenue F104A	
CEO City and Zip Code: Chicago, IL 60608 CEO Telephone Number: 773/257-6434	
CEO releptione Number: 773/257-6434	
Type of Ownership of Applicants	
☑ Non-profit Corporation ☐ Partnership ☐ For-profit Corporation ☐ Governmental	
Limited Liability Company Sole Proprietorship	☐ Other
 Corporations and limited liability companies must provide an Illinois ce standing. 	ertificate of good
 Partnerships must provide the name of the state in which they are orga address of each partner specifying whether each is a general or limited 	
address of each partner specifying whether each is a general or limited	partiter.
APPEND DOCUMENTATION AS ATTACHMENT 1 IN NUMERIC SEQUENTIAL ORDER AFTER APPLICATION FORM.	THE LAST PAGE OF THE
Primary Contact [Person to receive ALL correspondence or inqui	ries]
Name: Jack Axel	
Title: President	
Company Name: Axel & Associates	
Address: 675 North Court, Suite 210, Palatine, IL 60067	
Telephone Number:847-776-7101	
E-mail Address: jacobmaxel@msn.com	
Fax Number:	
Additional Contact [Person who is also authorized to discuss the	application for
exemption permit]	

Page 1

APPLICATION FOR PERMIT- 01/2017 Edition

Title: Vice President, Strategy and Marketing
Company Name: Sinai Health System 4
Address: 1500 South Fairfield Avenue, Chicago, IL 60608
Telephone Number: 773-257-6441
E-mail Address: paul.berrini@sinai.org
Fax Number:

Name: Clare Connor
Title: Partner
Company Name: McDermott, Will & Emery LLP
Address: 444 West lake Street Chicago, II 60606
Telephone Number: 312-984-3365
E-mail Address: cconnor@mwe.com
Fax Number:

Post Exemption Permit Contact

[Person to receive all correspondence subsequent to permit issuance-THIS PERSON

	BE EMPLOYED BY THE LICENSED HEALTH CARE FACILITY AS DEFINED LCS 3960]
	achel Dvorken
	cutive Vice President and General Counsel
	Name: Sinai Health System
	1500 South Fairfield Avenue, Chicago, Il 60608
	e Number: 773-257-5733
E-mail Ac	ldress: Rachel.dvorken@sinai.org
Fax Num	ber:
Exact Leg Address of Street Ad Proof of ownersh of the co	whership this information for each applicable site] gal Name of Site Owner: Holy Cross Hospital of Site Owner: 2701 West 68 th Street, Chicago, II 60629 Idress or Legal Description of the Site: ownership or control of the site is to be provided as Attachment 2. Examples of proof of ip are property tax statements, tax assessor's documentation, deed, notarized statement orporation attesting to ownership, an option to lease, a letter of intent to lease, or a lease. DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE AGE OF THE APPLICATION FORM.
Provide	this information for each applicable facility and insert after this page.]
Exact Le	gal Name: Holy Cross Hospital
Address:	2701 West 68 th Street, Chicago, IL 60629
F	Non-profit Corporation
o F	Corporations and limited liability companies must provide an Illinois Certificate of Good Standing. Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner. Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.
LAST PA	DOCUMENTATION AS ATTACHMENT 3, IN NUMERIC SEQUENTIAL ORDER AFTER THE AGE OF THE APPLICATION FORM.
Provide (entity wh	zational Relationships for each applicant) an organizational chart containing the name and relationship of any person or o is related (as defined in Part 1130.140). If the related person or entity is participating in the nent or funding of the project, describe the interest and the amount and type of any financial ion.

APPEND DOCUMENTATION AS ATTACHMENT 4, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Flood Plain Requirements

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2006-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements, please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at www.FEMA.gov or www.illinoisfloodmaps.org. This map must be in a readable format. In addition, please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2006-5 (http://www.illinois.gov/sites/hfsrb).

APPEND DOCUMENTATION AS <u>ATTACHMENT 5.</u> IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Historic Resources Preservation Act Requirements

[Refer to application instructions.]

Provide documentation regarding compliance with the requirements of the Historic Resources Preservation Act.

APPEND DOCUMENTATION AS <u>ATTACHMENT 6.</u> IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

DESCRIPTION OF PROJECT

1. Project Classification

[Check those applicable - refer to Part 1110.40 and Part 1120.20(b)]

_	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
Part 1	110 Classification:	
	Change of Ownership	
	Discontinuation of an Existing Health Care Facility or of a category of service	
	Establishment or expansion of a neonatal intensive care or beds	

2. Narrative Description

In the space below, provide a brief narrative description of the project. Explain **WHAT** is to be done in **State Board defined terms**, **NOT WHY** it is being done. If the project site does NOT have a street address, include a legal description of the site. Include the rationale regarding the project's classification as substantive or non-substantive.

The applicant proposes to discontinue Holy Cross Hospital's 34 –bed inpatient comprehensive physical rehabilitation ("rehabilitation") unit. The hospital is located at 2701 West 68th Street in Chicago.

Since becoming a member of Sinai Health System in 2012, Holy Cross Hospital has sought to identify opportunities to improve care by innovating across its service delivery profile through inter-System collaboration. This discontinuation would allow for the consolidation of services to Schwab Rehabilitation Hospital, also a member of Sinai Health System and located just 6.6 miles north, and would be consistent with best practice trends for community, home-based, subacute and acute treatment for rehabilitation care. Holy Cross has experienced a 34% decline in admissions since 2013 as patients have migrated to community, home based and specialty rehabilitation hospital settings. Patients requiring higher complexity inpatient rehabilitation services have benefited from the more comprehensive range of services provided by a rehabilitation specialty hospital such as Schwab.

Access to rehabilitation services for the patient population traditionally served by Holy Cross Hospital will not be significantly impacted by the proposed discontinuation. Holy Cross Hospital will be working with area health providers to coordinate other rehabilitation services, such as sub-acute and home based, and will utilize Schwab Rehabilitation Hospital for inpatient care. Schwab Rehabilitation Hospital will provide on-site liaison assistance to evaluate and facilitate the transfer of patients needing this level of care.

Rehabilitation outpatient and medical-unit therapy services will continue to be available for patients at Holy Cross Hospital.

Project Costs and Sources of Funds (Neonatal Intensive Care Services only)

Complete the following table listing all costs (refer to Part 1120.110) associated with the project. When a project or any component of a project is to be accomplished by lease, donation, gift, or other means, the fair market or dollar value (refer to Part 1130.140) of the component must be included in the estimated project cost. If the project contains non-reviewable components that are not related to the provision of health care, complete the second column of the table below. Note, the use and sources of funds must be equal.

USE OF FUNDS	and Sources of Fund	NONCLINICAL	TOTAL
Preplanning Costs	<u> </u>	HOHOEMIOAL	101742
Site Survey and Soil Investigation			
Site Preparation			
Off Site Work			
New Construction Contracts			
Modernization Contracts			
Contingencies			
Architectural/Engineering Fees			
Consulting and Other Fees	-		
Movable or Other Equipment (not in construction contracts)			
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment			
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS			\$0
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities			
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS			\$0

NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT 7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Related Project Costs

Provide the following information, as applicable, with respect to any land related to the project that will be or has been acquired during the last two calendar years:

Land acquisition is related to project Purchase Price: \$ Fair Market Value: \$	☐ Yes
The project involves the establishment of a new facility	or a new category of service
Yes No	or a new category or service
If yes, provide the dollar amount of all non-capitalized through the first full fiscal year when the project achieve 1100.	operating start-up costs (including operating deficits s or exceeds the target utilization specified in Part
Estimated start-up costs and operating deficit cost is \$	<u> </u>
Project Status and Completion Schedu	
For facilities in which prior permits have been issue	
Indicate the stage of the project's architectural drawings	3:
_	
	☐ Preliminary
☐ Schematics	☐ Final Working
Anticipated project completion date (refer to Part 1130.1	140): November 1, 2017
Indicate the following with respect to project expenditure 1130.140):	es or to financial commitments (refer to Part
☐ Purchase orders, leases or contracts pertain Financial commitment is contingent upon permi "certification of financial commitment" documen Contingencies ☐ Financial Commitment will occur after permi	t issuance. Provide a copy of the contingent t, highlighting any language related to CON
APPEND DOCUMENTATION AS <u>ATTACHMENT 8.</u> IN LAST PAGE OF THE APPLICATION FORM.	NUMERIC SEQUENTIAL ORDER AFTER THE
State Agency Submittals [Section 1130.	620(c)]
Are the following submittals up to date as applicable:	020(0/]
Cancer Registry	
☐ Cancer Registry	***************************************
☐ All formal document requests such as IDPH Que	estionnaires and Annual Red Reports been
All reports regarding outstanding permits	
submitted All reports regarding outstanding permits Failure to be up to date with these requirements deerned in complete and no extension.	will result in the application for permit being
Commission Expelentically bemeeb	
Commission	

CERTIFICATION

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives are:

- in the case of a corporation, any two of its officers or members of its Board of Directors;
- in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist);
- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

The undersigned certifies that he or she has the behalf of the applicant entity. The undersigned provided herein, and appended hereto, are compared to the com	dures of the Illinois Health Facilities Planning Act. authority to execute and file this Application on further certifies that the data and information
SIGNATURE	SIGNATURE FARMEN
Karen Teitelbaum PRINTED NAME	Lori Pacura LORI PACURA PRINTED NAME
CEO, Sinal Health System PRINTED TITLE	President, Holy Cross Hospital PRINTED TITLE
Notarization: Subscribed and sworn to before me this day of August 200	Notarization: Subscribed and sworn to before me this day of
Signature of Notary	Signalure of Notary
Seal "OFFICIAL SEAL" ROSA M ARELLANO Notary Public, State of Illinois Commission Expires 11"0:2020 *Insert the Ethical Seal Seal Seal Seal Seal Seal Seal Se	Seal "OFFICIAL SEAL" ROSA M ARELLANO Notary Public, State of Illinois

Notary Public, State of Illinois My Commission Expires 11/30/2020

SECTION II. DISCONTINUATION

This Section is applicable to the discontinuation of a health care facility maintained by a State agency. **NOTE:** If the project is solely for discontinuation and if there is no project cost, the remaining Sections of the application are not applicable.

Type of Discontinuation

	Discontinuation of an Existing Health Care Facility
\boxtimes	Discontinuation of a category of service

<u>Criterion 1110.130 - Discontinuation</u>

READ THE REVIEW CRITERION and provide the following information:

GENERAL INFORMATION REQUIREMENTS

- 1. Identify the categories of service and the number of beds, if any, that are to be discontinued.
- 2. Identify all of the other clinical services that are to be discontinued.
- Provide the anticipated date of discontinuation for each identified service or for the entire facility.
- 4. Provide the anticipated use of the physical plant and equipment after the discontinuation occurs.
- 5. Provide the anticipated disposition and location of all medical records pertaining to the services being discontinued, and the length of time the records will be maintained.
- 6. For applications involving the discontinuation of an entire facility, provide certification by an authorized representative that all questionnaires and data required by HFSRB or DPH (e.g., annual questionnaires, capital expenditures surveys, etc.) will be provided through the date of discontinuation, and that the required information will be submitted no later than 90 days following the date of discontinuation.
- 7. Upon a finding that an application to close a health care facility is complete, the State Board shall publish a legal notice on 3 consecutive days in a newspaper of general circulation in the area or community to be affected and afford the public an opportunity to request a hearing. If the application is for a facility located in a Metropolitan Statistical Area, an additional legal notice shall be published in a newspaper of limited circulation, if one exists, in the area in which the facility is located. If the newspaper of limited circulation is published on a daily basis, the additional legal notice shall be published on 3 consecutive days. The legal notice shall also be posted on the Health Facilities and Services Review Board's web site and sent to the State Representative and State Senator of the district in which the health care facility is located. In addition, the health care facility shall provide notice of closure to the local media that the health care facility would routinely notify about facility events.
- 8. Provide attestation that the facility provided the required notice of the facility or category of service closure to local media that the health care facility would routinely notify about facility events. The supporting documentation shall include a copy of the notice, the name of the local media outlet, the

date the notice was given, and the result of the notice, e.g., number of times broadcasted, written, or published. Only notice that is given to a local television station, local radio station, or local newspaper will be accepted.

REASONS FOR DISCONTINUATION

The applicant shall state the reasons for the discontinuation and provide data that verifies the need for the proposed action. See criterion 1110.130(b) for examples.

IMPACT ON ACCESS

- 1. Document that the discontinuation of each service or of the entire facility and whether or not it will have an adverse effect upon access to care for residents of the facility's market area.
- 2. Document that a written request for an impact statement was received by all existing or approved health care facilities (that provide the same services as those being discontinued) located within 45 minutes travel time of the applicant facility.

APPEND DOCUMENTATION AS <u>ATTACHMENT 10</u>, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION VII. 1120.130 - FINANCIAL VIABILITY - Not Applicable

All the applicants and co-applicants shall be identified, specifying their roles in the project funding or guaranteeing the funding (sole responsibility or shared) and percentage of participation in that funding.

Financial Viability Waiver

The applicant is not required to submit financial viability ratios if:

1. "A" Bond rating or better

2. All of the projects capital expenditures are completely funded through internal sources

3. The applicant's current debt financing or projected debt financing is insured or anticipated to be insured by MBIA (Municipal Bond Insurance Association Inc.) or equivalent

 The applicant provides a third party surety bond or performance bond letter of credit from an A rated guarantor.

See Section 1120.130 Financial Waiver for information to be provided

APPEND DOCUMENTATION AS <u>ATTACHMENT 17</u>, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

The applicant or co-applicant that is responsible for funding or guaranteeing funding of the project shall provide viability ratios for the latest three years for which audited financial statements are available and for the first full fiscal year at target utilization, but no more than two years following project completion. When the applicant's facility does not have facility specific financial statements and the facility is a member of a health care system that has combined or consolidated financial statements, the system's viability ratios shall be provided. If the health care system includes one or more hospitals, the system's viability ratios shall be evaluated for conformance with the applicable hospital standards.

	Historical 3 Years	Projected
Enter Historical and/or Projected Years:		
Current Ratio		
Net Margin Percentage		
Percent Debt to Total Capitalization		
Projected Debt Service Coverage		
Days Cash on Hand		
Cushion Ratio		

Provide the methodology and worksheets utilized in determining the ratios detailing the calculation and applicable line item amounts from the financial statements. Complete a separate table for each co-applicant and provide worksheets for each.

2. Variance

Applicants not in compliance with any of the viability ratios shall document that another organization, public or private, shall assume the legal responsibility to meet the debt obligations should the applicant default.

APPEND DOCUMENTATION AS <u>ATTACHMENT 18</u>, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION VIII. 1120.140 - ECONOMIC FEASIBILITY - NOT APPLICABLE

This section is applicable to all projects subject to Part 1120.

A. Reasonableness of Financing Arrangements

The applicant shall document the reasonableness of financing arrangements by submitting a notarized statement signed by an authorized representative that attests to one of the following:

- That the total estimated project costs and related costs will be funded in total with cash and equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation; or
- 2) That the total estimated project costs and related costs will be funded in total or in part by borrowing because:
 - A) A portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or
 - B) Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

B. Conditions of Debt Financing

This criterion is applicable only to projects that involve debt financing. The applicant shall document that the conditions of debt financing are reasonable by submitting a notarized statement signed by an authorized representative that attests to the following, as applicable:

- 1) That the selected form of debt financing for the project will be at the lowest net cost available;
- 2) That the selected form of debt financing will not be at the lowest net cost available, but is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional indebtedness, term (years), financing costs and other factors:
- That the project involves (in total or in part) the leasing of equipment or facilities and that the expenses incurred with leasing a facility or equipment are less costly than constructing a new facility or purchasing new equipment.

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

1. Identify each department or area impacted by the proposed project and provide a cost and square footage allocation for new construction and/or modernization using the following format (insert after this page).

	COST A	ND GROS	S SQUA	RE FEE	T BY DEP	PARTME	NT OR SEF	RVICE	
5	Α	В	С	D	E	F	G	Н	
Department (list below)	Cost/Squ New	uare Foot Mod.	Gross : Ne Cir	w	Gross S Mo Cire	d.	Const. \$ (A x C)	Mod. \$ (B x E)	Total Cost (G + H)
Contingency									
TOTALS									
* Include the p	ercentage	(%) of spa	ace for cir	culation			•		

D. Projected Operating Costs

The applicant shall provide the projected direct annual operating costs (in current dollars per equivalent patient day or unit of service) for the first full fiscal year at target utilization but no more than two years following project completion. Direct cost means the fully allocated costs of salaries, benefits and supplies for the service.

E. Total Effect of the Project on Capital Costs

The applicant shall provide the total projected annual capital costs (in current dollars per equivalent patient day) for the first full fiscal year at target utilization but no more than two years following project completion.

APPEND DOCUMENTATION AS <u>ATTACHMENT 19</u>, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION IX. SAFETY NET IMPACT STATEMENT (DISCONTINUATION ONLY)

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for <u>ALL SUBSTANTIVE PROJECTS AND PROJECTS TO DISCONTINUE STATE-OWNED HEALTH CARE FACILITIES</u> [20 ILCS 3960/5.4]:

- 1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.
- 2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.
- 3. How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

Safety Net Impact Statements shall also include all of the following:

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.

- 2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.
- 3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

A table in the following format must be provided as part of Attachment 40.

t Information p	er PA 96-0031	
CHARITY CA	RE	
Year	Year	Year
	:	
MEDICAID		,
Year	Year	Year
	CHARITY CAI Year	MEDICAID

APPEND DOCUMENTATION AS <u>ATTACHMENT 20</u>, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION X. CHARITY CARE INFORMATION (CHOW ONLY)

Charity Care information MUST be furnished for ALL projects [1120.20(c)].

- 1. All applicants and co-applicants shall indicate the amount of charity care for the latest three <u>audited</u> fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.
- 2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.
- 3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

Charity care" means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer (20 ILCS 3960/3). Charity Care <u>must</u> be provided at cost.

A table in the following format must be provided for all facilities as part of Attachment 41.

CHARITY CARE				
	Year	Year	Year	
Net Patient Revenue				
Amount of Charity Care (charges)				
Cost of Charity Care				

APPEND DOCUMENTATION AS <u>ATTACHMENT 21</u>, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

After paginating the entire completed application indicate, in the chart below, the page numbers for the included attachments:

INDEX OF ATTACHMENTS					
TTACHMEN'	т	PAGES			
1	Applicant Identification including Certificate of Good Standing	17			
2	Site Ownership	18			
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	19			
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	20			
5	Flood Plain Requirements				
6	Historic Preservation Act Requirements	İ			
7	Project and Sources of Funds Itemization	Ì			
8	Financial Commitment Document if required				
9	Cost Space Requirements	j			
10	Discontinuation	21-27			
11	Background of the Applicant				
12	Purpose of the Project	j			
13	Alternatives to the Project				
	Service Specific:				
14	Neonatal Intensive Care Services				
15	Change of Ownership	1			
	Financial and Economic Feasibility:				
16	Availability of Funds				
17	Financial Waiver				
18	Financial Viability				
19	Economic Feasibility				
20	Safety Net Impact Statement	28			
21	Charity Care Information	29			

File Number

2073-273-3



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of

Business Services. I certify that

HOLY CROSS HOSPITAL. A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON OCTOBER 10, 1929, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THIS GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



In Testimony Whereof, I hereto set

my hand and cause to be affixed the Great Seal of the State of Illinois, this 17TH day of JULY A.D. 2017 .

Automoration #, 171980/1902 verifable until 57:17.2-18 Automoration at, http://www.nybendrocklings.com esse White

Attachment 1



f. Lori Pacura, President of Holy Cross Hospital do hereby attest that Holy Cross Hospital owns the property located at 2701 West 68th Street in Chicago where the Rehabilitation Unit is located.

Signed and sworn to Before me on this 42 day day of 400 2017

OFFICIAL SEAL
DEBORAN WORLER
WEETER PASSES - SEASO OF METANIS
MY CONTRESSESS EXPISE OUR 25, 2018

ALACAMAN WORLES

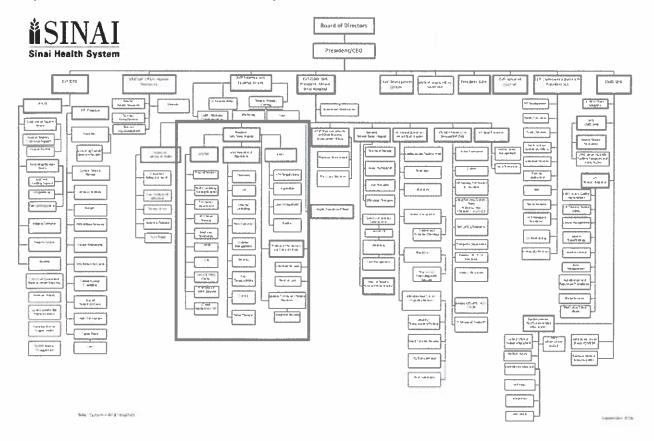


Persons with 5% o	or greater interest	in the licensee r	must be identified	with the %
ownership				

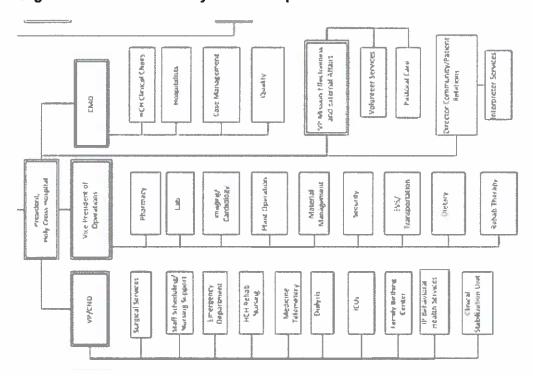
N/A

Holy Cross Hospital is a non-profit organization.

Organizational Chart - Sinai Health System



Organizational Chart - Holy Cross Hospital



Discontinuation

General Information Requirements

Holy Cross Hospital of Chicago ("Holy Cross") proposes to discontinue its 34-bed inpatient rehabilitation category of service, effective November 1, 2017. Holy Cross' inpatient rehabilitation admissions have declined by 34% since 2013. No other categories of service or clinical services are intended to be discontinued.

The space currently occupied by Holy Cross' inpatient rehabilitation unit will be used for the future expansion of existing services, although no specific use has been identified at this time.

Medical records of patients discharged from the rehabilitation unit will be maintained by the hospital, consistent with the hospital's health record retention policies.

A copy of the public notice published in the Chicago Sun Times on July 24, 2017, relating to the proposed discontinuation is attached.

Chicago Sun-Times Certificate of Publication

Chicago Sumitimes, does hereby certy it has published the standard advertiments in the hotowing secular newspapers. Ad newspapers meet illinois Compiled datable regularments for publication of hotoes per Chapter 715 ILCS 90.01 et seq. R.S. 1874, 9728 Scc 1, EFF. July 1, 1874. Amendad by Lawa 1953, P1494, EFF. July 17, 1959. Formerly III. Rev. Stat. 1991, CHICO. P.
Note: Notice appears in the following checked positions.

Chicago Sun-Times

PUBLICATION DATEDLE GROUDELL

IN WITNESS WHEREOF, the understyned, being duty authorized.

- 100

Jerony Cases Account Manager - Public Legal Nonces

This case they of any 2017 A.D.

MOUNT BINN HOSPITAL 1900 S FARRISELD AVE AARON ROSAMA DIGITAL WARRETING SPECIALIST CARCAGO JE STOR

Discontinuation (Continued)

Reasons for Discontinuation

The reasons for proposing the discontinuation of the inpatient rehabilitation unit at Holy Cross are:

- Demand for inpatient rehabilitation services at Holy Cross has declined by 34% since 2013 with the trend expected to continue.
- The consolidation is consistent with best practice trends for community, home-based, sub-acute and acute treatment for rehabilitation care.
- The opportunity to consolidate services efficiently and efficaciously within the System to Schwab Rehabilitation Hospital, which has ample capacity, aligns with best practices to advance care for patients with conditions of greater complexity by providing improved access to a more comprehensive range of services.

The below table illustrates the ability for Schwab to adequately absorb the consolidated volumes at what will be considered peak levels. As it is unlikely all admissions would choose to transfer to Schwab, and at the same time equally likely that area demand will decrease for inpatient rehabilitation, we expect the true demand post the proposed consolidation to be less than those stated below.

	Admissions	Patient Days	Average Daily Census	IP Rehabilitation Beds	CON Occupancy %
Schwab (2016)	1112	15342	43	81	53%
Holy Cross Hospital (2016)	321	3891	11	34	32%
Schwab (Consolidated)	1433	19233	53	81	65%

Discontinuation (Continued)

Impact on Access

The impact on access will not have an adverse impact on access to services for Holy Cross Hospital's traditional patient population. This is due to the availability of inpatient rehabilitation services at Schwab Rehabilitation Hospital as evidenced above, as well as reasonable access to regional hospital and non-hospital centers providing the service such as skilled nursing facilities.

Consistent with the requirements of Section 1110.130, letters requesting an impact statement were sent to all hospitals providing inpatient pediatrics units located within 36 minutes of Holy Cross Hospital. Below is a listing of those hospitals:

Advocate Illinois Masonic Medical Center	Louis A. Weiss Memorial Hospital	Mercy Hospital & Medical Center	Presence Resurrection Medical Center
Presence Saint Joseph Hospital Chicago	Presence Saint Mary of Nazareth Hospital	Shirley Ryan Ability Lab	Rush University Medical Center
Shriner's Hospital for Children	Swedish Covenant Hospital	University of Illinois Hospital & Health Science System	Adventist La grange Memorial Hospital
Advocate Christ Medical Center	Franciscan St. James Health – Chicago Heights	Ingalls Memorial Hospital	

Copies of responses received are attached, and should any additional responses be received subsequent to this COE application's filing, they will be forwarded to HFSRB Staff. In addition, photocopies of the Certified Mail delivery receipts returned to Holy Cross Hospital are attached. Those not yet returned will be sent upon receipt by Holy Cross Hospital.

Discontinuation Attachment 10

By Certified Mail Delivery Receipt Requested

July XX, 2017

[Insert Name]

[Address line 1]

[Address line 2]

[Address line 3]

RE: Proposed Discontinuation of Inpatient Rehabilitation at Holy Cross Hospital

Dear [Insert name]

Holy Cross Hospital intends to file a Certificate of Exemption ("COE") application with the Illinois Health Facilities and Review Board ("IHFSRB"), addressing the discontinuation of the hospital's inpatient rehabilitation unit so they may be centralized at Schwab Rehabilitation Hospital. Holy Cross Hospital will continue to provide outpatient and medical unit rehabilitation therapy services.

Through this letter and consistent with the provisions of Section 1110.130, you are requested, should you elect to do so, to provide an impact statement, consistent with the identified requested information contained in the above referenced section; including: 1) whether your hospital has or will have available capacity to accommodate a portion or all of Holy Cross Hospital's experienced caseload, and 2) whether any restrictions or limitations preclude providing service to residents of Holy Cross Hospital's service area.

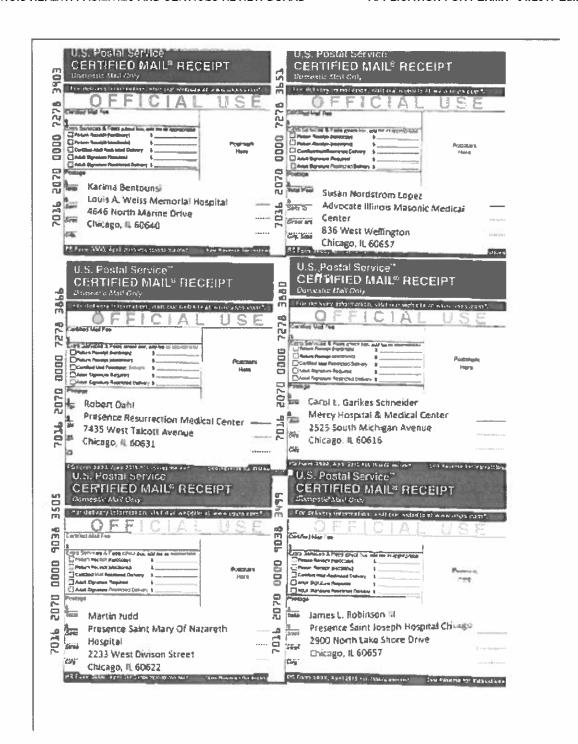
The anticipated date for discontinuation is by November 1, 2017.

During the 24 month period ending December 31, 2016, a total of 677 patients were admitted to Holy Cross Hospital's inpatient rehabilitation unit.

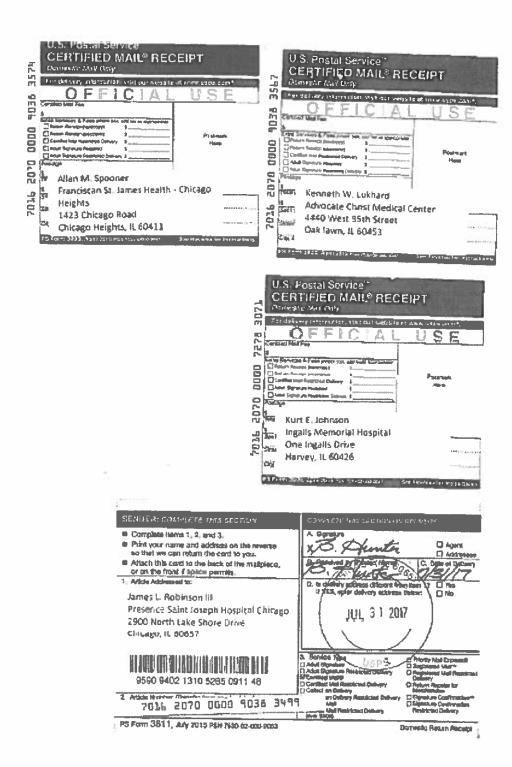
A copy of any response to this request received within 15 days of your receipt of this letter will be forwarded to the IHFSRB.

Sincerely,

Lori Pacura
President, Holy Cross Hospital



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Safety net Impact Statement

Section 1

Q1

Holy Cross Hospital believes that the consolidation of its inpatient services to Schwab Rehabilitation Hospital, just 6.6 miles north, with provision of on-site liaison from Schwab to evaluate and facilitate the transfer of patients, will help to ensure that ample access will be retained for this service and therefore will not have an adverse impact on essential safety net services within the community.

Q2

With the continued trend of decreasing demand at a year over year rate of 8.5% for inpatient rehabilitation services at Holy Cross and the ability to consolidate and support access to Schwab rehabilitation Hospital, which has ample capacity, Holy Cross Hospital believes that the project will not impact the ability of other providers or health care systems to subsidize safety net services.

Q3

Due to the above listed reasons, Holy Cross Hospital believes that other safety net providers in the area will not be negatively impacted.

Section 2

Holy Cross Hospital					
Safety Net Information per PA 96-0031					
CHARITY CARE					
Charity (# of patients)	2014	2015	2016		
Inpatient	260	240	363		
Outpatient	6,551	2,506	6,673		
Total	6,811	2,746	7,036		
Charity (cost In dollars)					
Inpatient	\$1,421,424	\$1,153,864	\$2,480,400		
Outpatient	\$2,305,616	\$4,530,195	\$5,603,100		
Total	\$3,727,040	\$5,684,059	\$8,083,500		
MEDICAID					
Medicaid (# of patients)	2014	2015	2016		
Inpatient	2,035	3,740	3,573		
Outpatient	18,393	11,994	33,889		
Total	20,428	15,734	37,462		
Medicaid (revenue)					
Inpatient	\$10,109,269	\$32,876,743	\$22,602,163		
Outpatient	\$3,230,733	\$7,323,613	\$12,543,221		
Total	\$13,340,002	\$40,200,356	\$35,145,384		

Charity Care Information Table

Holy Cross Hospital				
CHARITY CARE				
Net Patient Revenue	\$78,847,128	\$111,602,231	\$89,393,016	
Amount of Charity Care (Charges)	\$45,464,340	\$21,503,656	\$36,746,098	
Cost of Charity Care	\$3,727,040	\$5,684,059	\$8,083,500	

